

4

Ethical and Legal Environment

Learning Objectives

- Distinguish ethics and law
- Begin to identify and formulate a personal ethic
- Compare and contrast several moral philosophies
- Explicate the ethical principles that affect HSOs and managers
- Comprehend types of administrative and clinical ethics issues
- Conceptualize the means by which HSOs address ethics issues
- Understand the effects of law and regulation on managers and HSOs

Discussion Questions

1. *Describe the relationship between law and ethics. Which is the more demanding standard? Why? Identify and be prepared to explain examples other than those described in the chapter.*

The relationship between law and ethics is shown in Figure 4.1. Discussion should stress that the law is the minimum performance required. All persons are moral agents. As such, they are responsible for nonfeasance, malfeasance, and misfeasance, all of which have ethical implications. Every manager should have formulated a personal ethic (code of conduct) to guide behavior. Professions demand compliance with the law, but they have codes of ethics that hold members to higher standards.

Ethics is a more demanding standard than the law. Students should be asked to identify situations in which the law and ethics have the same required level of performance. Those identified should be probed on the basis of *what should be done*. The law will fall behind ethics in terms of expected performance.

2. *Identify health services laws or regulations based on 1) a utilitarian philosophy, 2) a deontological philosophy, and 3) elements of both. How compatible are these philosophies when included in the same law or regulation?*

Laws and regulations based on a utilitarian philosophy include 1) health planning legislation that emphasizes cost versus benefit (the greatest good for the greatest number) and 2) quality improvement organizations (QIOs), which review use and quality of services to Medicare patients. Laws and regulations that have a deontological basis include 1) Medicare, which reflects a right to health services for certain groups, regardless of other considerations, and 2) Medicaid, which is similar to Medicare, although the implementation varies. Examples of laws and regulations with mixed utilitarian and deontological philosophies include 1) the Taft-Hartley Act amendments, which allowed health workers to organize (deontological) and also sought to lessen labor unrest (the greatest good for the greatest number—utilitarian) and 2) the Occupational Safety and Health Administration (OSHA), which protects workers from unsafe conditions (recognizes worker dignity—deontological) and also seeks to reduce cost of worker injury to society (utilitarian).

Compatibility. The utilitarian (greatest good for the greatest number) and deontological (Golden Rule—do unto others as you would have them do unto you) philosophies are typically at odds. Primarily, this is because they stem from very different premises. Depending on the issue, they reflect different views and emphasize different goals and virtues. However, they may be used in complementary and compatible ways. Medicare's underlying philosophy is deontological. To implement a right to healthcare, however, it uses utilitarianism (e.g., diagnosis-related group [DRG]-based payment).

3. *What does a professional code of ethics reflect? How can enforcement be made meaningful? Must a profession "police" its standards? Why or why not?*

Professional codes of ethics reflect 1) expected minimum levels of performance and 2) aspirations. The expected minimum level of performance is what a profession asks of its affiliates and, thus, is formed from a consensus of what the profession thinks its members ought to do and/or ought to be. Aspirations are ultimate, perhaps unattainable, goals (e.g., "provide care to all, regardless of ability to pay"). They are goals toward which members of the profession should strive. Both provisions reflect societal expectations.

Responses to the question of how enforcement can be made meaningful should consider the purposes and usefulness of a code. A code is most meaningful to the profession if there is

enforcement. Enforcement requires a code to be specific so unacceptable performance is identifiable. If members don't know what is unacceptable, any enforcement is necessarily arbitrary and capricious, and members are denied substantive due process. Enforcement must also include a fair process so members whose conduct is reviewed receive procedural due process. Assuming specificity and substantive and procedural due process, enforcement is most meaningful if outcomes of disciplinary actions are reported to members, without disclosing the names of those involved. Such reporting 1) enhances members' knowledge of the code, 2) makes them aware of enforcement, and 3) informs them as to how provisions are interpreted. This makes the code a living document.

A profession must "police" its standards because a true profession regulates members' conduct. It is a meaningless exercise if beautiful words and high-sounding phrases are put into a code that lies unused. Self-regulation means that a profession must be precise in developing its views and statements, roles, and activities. This introspection strengthens the profession and, it is hoped, enhances its work, the ultimate goal of which is to assist in efficient delivery of high-quality health services.

4. Describe uses and limitations of codes of ethics that apply to HSOs/HSs. Should they be communicated to patients who are served by the organization? If so, how?

The codes of ethics that apply to HSOs have been developed by organizations such as the American Hospital Association (AHA) and the Department of Veterans Affairs. Some associations such as LeadingAge, whose members are nursing facilities, do not have a national code of ethics but rely on the codes developed by state chapters. Codes of ethics are useful to the extent that they provide general guidance to HSOs and sensitize management and staff to issues and concerns. They are limited because the guidance lacks specificity. It is left to HSO/HS management and staff to apply the general guidelines in these documents. Codes of ethics should be communicated to patients who use the organizations. HSOs often hang framed copies of the codes that apply to them in their lobbies. This shows good intention but is more formality than meaningful effort. Some HSOs provide a copy of the code to each patient on admission. This is preferred. Given all that is happening to patients, this may or may not have an effect. It should be done, nonetheless.

5. What is the HSO's/HS's role regarding patient rights? Are some duties or obligations surpassed by the organization's duty to patients? If so, give examples of where this occurs.

The HSO's/HS's role regarding patient rights has ethical and legal aspects. Ethics demands that all efforts are made to protect patient rights. HSOs must obey the law, which is less demanding in terms of intent but may be more so in application (e.g., fines, imprisonment). Students may argue on the basis of act utilitarianism, which holds that for each event a decision is based on achieving the greatest good for the greatest number. This view ignores the position of the utilitarian philosopher John Stuart Mill that the first consideration is the liberty (and the rights) of the individual. Students may assert that the HSO/HS and its staff have rights, too. This is true, but it ignores why the HSO exists. The importance of patients' rights and the distinction between ethical and legal bases must be made clear.

Some duties or obligations are surpassed by the HSO's duty to patients. The instructor should begin discussion of this concept by identifying superior duties. Some students may argue that the manager's duty of fidelity to the employer (the corporation through the GB) and to the shareholders of investor-owned HSOs/HSs is greater than the duty to patients. This fails to support the basic concept that the profession expects HSOs to be managed for the benefit of patients. A balance between duty to the HSO and duty to the patients is required, however, and the weights of duties to each vary with the situation and right(s) being protected. For example, the duty of loyalty to an HSO does not include lying to patients, and the HSO's

duty to patients does not include providing unlimited free care. Further, the duty to patients requires that managers ensure that they give informed consent. Ask students to support their positions by more than gut feeling or ethical relativism. They should use ethical principles to support their positions.

6. *Define fiduciary. Give some examples in and out of health services. Are HSOs/HSs and their services unique in terms of this concept? If so, how?*

Black's Law Dictionary defines *fiduciary* as a relationship “founded on trust or confidence reposed by one person in the integrity and fidelity of another.”¹ A fiduciary has a superior position of knowledge or power and a duty to exercise it with due regard to the interests of persons who have placed their confidence in the fiduciary. Health services fiduciaries include managers, physicians, and GB members. Nonhealth services fiduciaries include trustees, managers, and professors.

HSOs/HSs and their services are unique in terms of this concept. Health services are a social good and are humanitarian in nature. The public expects HSOs and those working in them, especially physicians, to meet a standard higher than the law requires. HSO managers must strive to meet this expectation.

7. *Define conflict of interest. Give examples in HSOs or HSs. How can they be minimized? What is the manager's role?*

A conflict of interest occurs when someone has two duties, meeting one of which results in an inability to meet the other. A duality of interests creates the potential for a conflict of interest. A potential conflict of interest may or may not become an actual conflict of interest, and the two should be distinguished. For example, a business office supply wholesaler who serves on an HSO GB may wish to do business with the HSO. He contracts with it to sell comparable merchandise at a lower price than competitors. These two relationships (duality of interests) raise a potential conflict of interest, which becomes an actual conflict if, for example, the wholesaler delivers shoddy merchandise and uses his influence as a GB member to continue the relationship. Another example of a duality of interests that raises a potential conflict of interest is the case in which a physician serves on a PSO review committee that reviews her charts. It becomes an actual conflict if she uses her membership on the committee to gain approval for her clinical work, which is poor quality.

In assessing how HSOs and their managers can minimize conflicts of interest, the conflict of interest statements from the AHA, the American College of Healthcare Executives (ACHE), and other professional groups should be discussed. Managers of governmental HSOs are subject to conflict of interest statutes and regulations. These statements emphasize disclosure of potential conflicts, which appropriately puts the burden on the person most aware of facts about a duality of interests that could lead to an actual conflict of interest. Financial disclosure statements provide baseline information about managers. Managers must be alert to, and take steps to prevent or minimize, potential or actual conflicts of interest. This requires developing and maintaining high ethical standards in the profession, including ferreting out those who knowingly engage in conflicts of interest and educating those ignorant of them.

8. *What should be the role of managers in allocating resources at the micro- and macro-levels? What can be done to reduce the likelihood that ethical problems will arise?*

Managers are involved in allocating resources at both the macro- and micro-levels as decision makers, and as facilitators and implementers of decisions made by others. Clinical and administrative decisions should be distinguished. Most involvement by managers in clinical decisions is at the macro-level. Managers develop, and should participate in, the process by which decisions about capital equipment for clinical care are made, for example. Involvement in micro-clinical decisions is less direct and more facilitative. Managers must establish effective processes

to review use of HSO resources (utilization review) by physicians (micro-decisions). It is also important that managers support the training of staff members who make micro-clinical decisions. The roles of managers in macro- and microadministrative decision making depend on their level in the hierarchy. There should be no walls between PSO and management. PSO members must participate in administrative decision making.

Planning and communication are critical to preventing clinical and administrative ethical problems. Management must anticipate ethical issues and develop policies within the context of the organizational philosophy and values. HSO policies are implemented through procedures. Issues addressed should include advance medical directives, do-not-resuscitate orders, patient consent, futile care policy, conflict of interest, and staff accepting gratuities. HSO policies and procedures must be communicated to staff and periodically reinforced by education and, if necessary, enforcement. Procedures must be evaluated to determine if they are achieving the intended results.

9. What types of experimentation might occur in HSOs/HSs? In terms of safeguards, distinguish surgical experimentation from that involving drugs and devices. How can patients be protected?

Through their HSO components, many HSs participate in clinical trials such as testing new drugs or biologicals. Others are sites for Food and Drug Administration (FDA)-sanctioned studies of new medical devices, such as artificial hearts. These are straightforward experiments. Other HSOs become involved in experimenting—sometimes without knowing it—when, for example, a surgeon develops and uses a new surgical technique. New uses of devices and drugs are known as innovative treatment; however, this is experimenting too. Broadly defined, experimentation is any treatment not accepted by a respectable minority in medicine. Surgical experimentation is distinguished from that involving drugs, biologicals, and devices in that it is not regulated by the FDA, although a few states regulate it.

How Patients Can Be Protected. HSOs, especially hospitals, involved in organized research should have institutional review boards (IRBs). The Department of Health and Human Services (DHHS) requires IRBs for all research funded by it. Other federal agencies use IRBs or an equivalent. IRBs focus on consent and the protection (safety) of research subjects. HSO staff must know the differences between standard and experimental treatment, including innovative therapies, and understand that it is their duty to ensure that patient autonomy (the right to consent) is maintained and to protect patients from harm.

10. Identify the types of advance medical directives (AMDs). What are their effects on HSOs? How do managers ensure that HSOs interact effectively with patients in terms of AMDs?

Examples of advance medical directives are living wills, natural death act statutes, and do-not-resuscitate (DNR) orders. Patients may execute durable powers of attorney and powers of attorney for healthcare decisions to give surrogates authority to make decisions for them if they become incapacitated. Sometimes, such legal documents are listed as advance medical directives. Technically, however, they are not—the surrogate may make a decision that the patient would *not* make if the patient were able to make a decision.

Living wills were developed by a private organization. Absent a state statute recognizing their legal status, such as a natural death act statute, HSOs and clinicians are morally, but not legally, bound by living wills. HSOs and clinicians should use living wills to guide actions. Natural death act statutes recognize a person's legal right to control treatment at the end of life, provided certain conditions are present and legal requirements are met. If so, the HSO and its caregivers are legally bound to follow the patient's wishes; failing to do so may mean civil or even criminal penalties. Most states have natural death act statutes or their equivalent. State statutes, plus requirements of the federal Patient Self-Determination Act, mean that HSOs are widely affected by issues of advance medical directives.

To ensure that they interact effectively with patients, HSOs must have policies and procedures that address the issues raised by advance medical directives. Staff members must be trained to implement them. Interacting effectively with patients and family regarding advance medical directives may be a new role for some staff members, and the HSO must prepare them to do so effectively. It is important that the HSO evaluates how well policies and procedures on advance medical directives are implemented.

11. What is euthanasia? What are the types of euthanasia? Distinguish euthanasia from physician-assisted suicide (PAS). Develop brief scenarios that highlight the differences between the various types of euthanasia and PAS.

Historically, *euthanasia* meant good death; *eu* *thanatos* means “a death free of pain.” The 20th century saw a change, however, and euthanasia began to be defined as mercy killing—a purposeful hastening of the person’s death. Types of euthanasia include voluntary active, involuntary active, voluntary passive, and involuntary passive. *Voluntary* and *involuntary* describe whether the person has consented. *Active* and *passive* describe whether death was hastened.

Physician-assisted suicide (PAS) occurs when the physician provides the means for suicide and may even initiate the first step, such as starting an intravenous solution to which the patient adds a deadly chemical. In PAS, however, the person undertakes the step that causes death. This act is defined as suicide. In contrast, active euthanasia involves the physician acting so as to cause the patient’s death.

The text describes the “work” of Dr. Jack Kevorkian, and students may draw on this to develop scenarios. The example of the Oregon Death With Dignity act and its requirements are a domestic application of PAS. International examples may be described as well. The media reports of “angels of death” (commonly RNs), who decide that seriously ill patients are better off dead, are examples of involuntary active euthanasia. Here, patient consent is neither sought nor needed; in effect the patient is murdered.

12. Some research indicates that the majority of patients are willing and able to participate in end-of-life decisions by speaking about their preferences for care. Do such findings diminish hospitals’ need to develop a futile care policy? Explain how futility theory is compatible with PAS.

The concept of futility theory is compatible with PAS. Often, patients who are the subjects of futile treatment discussions are too ill to give consent or use the assistance of a physician to commit suicide. Thus their use of PAS is moot. For some patients, however, PAS may offer an escape from application of futility, something legally possible in Oregon, Washington state, Montana, and Vermont at this writing. Almost all states have legislated against use of PAS.

The preliminary findings of the SUPPORT study suggested that the problem (in terms of numbers and cost) of futile treatment is overstated. Regardless of how common the demands for futile treatment are, however, even an occasional case will justify development of a policy. The fact that the HSO has a futility policy will help establish limits on continuing treatment when there is no hope of benefit from it. Further, existence of a futile care policy will encourage physicians to become more proficient in addressing this issue with patients (through advance medical directives) and family. The concept of “allow natural death” (AND) has gained favor as an alternate to aggressively intervening to try to “rescue” a patient whose prognosis is grim. AND provides comfort care and pain control, but does not allow use of significant interventions such as cardiopulmonary resuscitation and ventilator support. Palliative care is another concept of care available after diagnosis of a terminal illness. It is broader than hospice and is applied earlier. Palliative care includes attention to pain and symptom control, psychosocial distress, spiritual issues, and practical needs, and includes the patient and family throughout the continuum of care. Hospice care is provided after palliative care is no longer effective.²

Case Study 1

“What’s a Manager to Do?”³

This case alerts students to the moral obligations of managers who become aware of ethical lapses in HSOs/HSs. Managers are morally obliged to intervene to stop problems such as self-dealing, conflicts of interest, and misuse or diversion of organization assets and to take measures to prevent their recurrence. Even if no laws are broken, ethical lapses are important because they undermine the organizational values and diminish the desired culture of the organization. Further, the moral authority of those who engage in them is lessened, thus directly and indirectly encouraging ethical (and legal) lapses by others.

1. *Identify the ethical problem(s) that face the governing body members and the managers. Do similar problems face those not directly involved?*

GB members receiving grounds maintenance services (a personal benefit and a misuse/diversion of hospital resources) and those selling reagents at above market price (self-dealing [if this is actually occurring]) have actual conflicts of interest. Using their position on the GB in this manner violates their fiduciary duty to the HSO. Rine is aware of the problems; senior managers either know or should know. The managers of the HSO do not have a conflict of interest, but they have an ethical dilemma. They have a fiduciary duty to the HSO and a duty of loyalty to it. This obligates them to work in its best interests; allowing diversion or misuse of resources violates this obligation. They have an ethical (moral) duty to act. The scenario suggests a need for whistle-blowing, whether internal or external.

2. *Are the grounds maintenance and the sale of reagents, supplies, and equipment to the laboratory ethically different? State your reasons. Are the two likely to be distinguished in the “real world”?*

Providing grounds maintenance services to senior GB members is an ethical breach. Similarly, if true, selling to the laboratory at higher than market prices is an ethical breach. Although quantitatively different, both violate the fiduciary duty that GB members have to the HSO. Students may argue that these ethical lapses are different in the “real” world. The grounds maintenance could be characterized as a quid pro quo to senior GB members for their service to the HSO. In response, however, it should be asked why only senior GB members are given these services. Providing grounds maintenance may be a historical artifact if only GB members with long service receive this benefit. Given such a history, there may be reluctance to discontinue this “benefit.”

Sales to the laboratory are different. GB members using a position of authority for personal gain—the profit from selling *allegedly* overpriced reagents—are directly or indirectly putting money into their own pockets. This is stealing and is qualitatively different from using staff time for grounds maintenance. Both, however, deprive the HSO of resources and breach a fiduciary duty.

3. *What steps should managers like Rine take if they have the moral courage to risk their jobs to try to solve the problems? Short of risking their jobs, what steps could they take?*

First, Rine should demand that the director of maintenance provide data on the cost of caring for GB members’ grounds. These data could be used to persuade senior management as to the cost and the need to end the practice. If the director refuses to provide cost data, Rine should initiate disciplinary action for this insubordination up to and including dismissal. This will bring the issue into the open but may be high risk for Rine. Second, Rine could prohibit maintenance staff from going to the GB members’ homes and inform the GB members of the decision. In terms of the sale of *allegedly* overpriced reagents to the laboratory, Rine could work with the laboratory director to document the higher costs of buying from GB members.

These data would support competitive bidding and policies that prohibit or closely monitor purchasing goods and services from employees and GB members.

Lower-risk actions are indirect. First, Rine could outline the problems to senior management and seek their support to solve them. Invoking the ACHE Code of Ethics and suggesting that all managers have a fiduciary duty to the HSO may be persuasive. Second, Rine could work to establish an HSO-wide policy prohibiting or monitoring activities like those described in the case. Third, Rine could seek a higher budget for maintenance and justify it because of the services being provided to GB members. This would highlight in another way the costs of providing such services.

4. What sources of assistance are there for Rine outside the organization? How should they be involved?

External sources of assistance include professional associations and the media. Their use depends on the level of risk Rine is willing to accept. If Rine can document that senior managers who are affiliated with the ACHE (or similar professional associations) know about the problems, a complaint should be sent to the association's committee on ethics. This can be done anonymously, and the resulting investigation may produce change. Also, Rine could be a "deep throat" to the local media and stimulate an investigation. Finally, Rine could go public with the information that he has. This action would almost certainly result in dismissal. The rationale for firing Rine would be "disloyalty" to the organization.

Case Study 2

Bits and Pieces⁴

This case considers the propriety of managers accepting gratuities from vendors. Over time, even small gifts create relationships that diminish objectivity and, thus, lessen critical thinking about procurement of goods and services. HSOs have an obligation to support their managers and other staff with guidelines about accepting gratuities.

1. Develop arguments that support Mary Beth's position on the gratuities she has been receiving. List them in order of importance.

- Managers' receipt of gratuities is common and an accepted business practice.
- Social relationships and friendships have developed with sales representatives.
- The modest value of gratuities will not affect a manager's judgment.
- Gratuities compensate for the extra effort and work of being a manager.
- The gratuities being accepted cost the organization nothing.
- It is a common practice in health services, especially among groups such as physicians.

2. Describe the importance of business custom in the relationship Mary Beth has with the sales representatives. Should this influence the ethics of the situation?

Business custom is somewhat persuasive but not conclusive. Some organizations, such as government HSOs, control gratuities closely; others forbid them completely. One could argue that, if all sales representatives give gratuities, the influence is neutral. Then, however, the value of gratuities may become an issue. Also to be considered is the perception of corruption and conflicts of interest that will inevitably arise if gratuities are a common part of the organization's culture. The cohesiveness of the HSO's/HS's culture is diminished and will become antagonistic if some staff members receive gratuities and others do not. This dissonance will create jealousy and animosity, set employee against employee, and diminish teamwork. Most important is the fact that the manager's and organization's integrity is lessened. Their self-

image is eroded too. It becomes what philosophers call a slippery slope on which control and objectivity are more easily lost.

3. *Develop a policy regarding gratuities that Affiliated Nursing Homes and Rehabilitation Center could use. Identify the underlying ethical principles, and be prepared to defend the policy.*

Responses from students will include controls on gratuities. Options should be supported by ethical principles. Controlling gratuities is supported by the principles of respect for persons (fidelity—loyalty to the HSO) and beneficence (indirectly doing good for patients by effectively working for the HSO and controlling costs). The virtues of honesty and integrity should be identified. Students may try to use the concept of autonomy to justify no policy on gratuities. This is a false application of autonomy. Enhancing autonomy is appropriately focused on patients, not staff.

4. *Describe incidents from your own experience that are similar to the issues in the case. Did they have detrimental effects on the organization? Were they resolved? If so, how?*

HSO incidents are preferred; non-HSO examples can be used by analogy. Kantian deontology using the categorical imperative posits that the actions are inherently unethical because of the results from universalizing them. Such actions can also be shown to be unethical by measuring the negative effects of extending the behavior to the whole HSO or by making it more extreme. Such reasoning is rule utilitarian—measuring good and ungood produced. Students may argue situational ethics or ethical relativism (“it’s okay, everyone does it” or “if it’s okay for them, that’s fine with me”). Such positions are erroneous because the actions will adversely affect patient care, lessen the integrity of staff and HSO, and establish a culture of dishonesty, self-interest, and self-dealing.

Case Study 3

Understanding⁵

This case highlights problems related to consent that can arise when different providers are involved in the care of a patient. The providers are the nurse practitioner (NP), health department, gynecologist, and hospital. The gynecologist performed the hysterectomy and, therefore, not only is directly involved in Ms. Brown’s care, but also is the provider who has the clinical expertise as well as an ethical and legal duty to provide information as to risks, benefits, and alternatives and to actually obtain consent.

1. *Describe the role of each provider involved, including the hospital, regarding patient consent.*

The gynecologist has the primary ethical duty and legal obligation to provide the information needed for informed consent. The NP could be faulted for not providing more information—an ethical obligation—to the patient regarding the consequences of the hysterectomy. This could put the NP at odds with the MD and may be seen as usurping the MD’s role. Usually, the hospital has no legal obligation regarding consent, except to determine that the consent form has been signed by the patient and is in the medical record. Many hospitals take the ethically preferred step of speaking to the patient regarding the procedure to determine that the patient understands what is going to be done and the consequences of the procedure. The health department might be ethically faulted for not providing information such as pamphlets or videos as to the consequences of having various procedures, but it has no legal obligation to obtain informed consent. Given the number of treatments and procedures that might occur, this would be an unreasonably heavy burden.

2. *Describe how the roles are complementary. How are they different?*

Arguably, the roles of the NP, gynecologist, and hospital are complementary, even though they vary in their specific ethical and legal content and their implications. Based on the patient's statement that the NP had discussed the surgical option and its implications, the gynecologist might have assumed that Ms. Brown understood what was to be done and the implications of the surgery. The gynecologist erred and was negligent by not providing information about the risks and benefits of, and the alternatives to, having the hysterectomy. The roles are different in that the NP is unlikely to be clinically competent to discuss risks, benefits, and alternatives with the patient. Further, it is likely that physicians would consider an NP's involvement in consent to be inappropriate. The hospital and, to a lesser extent, the health department have an ethical obligation to help protect the patient's autonomy and the right to provide informed consent for treatment. This is a role that is very different from obtaining consent.

3. *Identify how a patient's age is important in the consent process.*

Patients must be competent to give legally valid consent. Competence is determined by mental state—the ability to understand the nature and consequences of what is being contemplated—and by the patient's age—patients below a certain age are presumed to be incapable of giving consent. Ms. Brown was 18 years of age at the time of the surgery. Presuming no other impediments and compatible state law, she was legally able to give consent. Ethically, it can be argued that, because of their inexperience, younger patients who are competent to give consent should receive extra attention and thoroughness during the consent process.

4. *Outline a process by which situations like Ms. Brown's could have been prevented.*

There is no certain way such situations can be prevented. It is possible, however, to reduce the likelihood that a patient will not receive the information needed to give informed consent. Improvements include the following:

- More information from the NP regarding possible outcomes of surgical intervention
- Greater health department efforts to communicate implications of various treatments
- Determination by the health department that referral physicians have effective consent processes
- Working with physicians—who have the primary role in consent—to improve consent processes
- Encouraging hospitals to confirm that patients understand the treatment and its implication(s)

Case Study 4

Allocation⁶

This case considers distribution of scarce, potentially lifesaving medical treatment, namely vaccines and antivirals. Addressed are the process for a countywide plan, contingency planning for a specific scenario, and the ethical framework(s) in which the distribution occurs. Given the nuclear, chemical, and biological threats from enemies and terrorists and the potential for naturally occurring viral pandemics, this type of planning is not an idle exercise.

1. *Which HSOs in Grant County should be included in the plan? Why?*

All HSOs in Grant County should be included in the plan and any contingency planning. This is necessary because an outbreak of a deadly communicable virus will affect large numbers of

the population, most of whom will need treatment. In addition, the staff in the HSOs county-wide must care for those already in their facilities, as well as the influx of new patients needing help. Coordinated, integrated efforts will result in a superior response to the threat.

2. What value system do you recommend as the underlying philosophy(ies) to guide allocation of scarce vaccines?

Distribution of vaccines (and antivirals) can proceed on two levels. First, to maximize the likelihood of the best result, certain categories of personnel must be given priority. This uses a utilitarian calculus and provides the greatest good for the greatest number. Given the threat, it is rational to do this. Vital services such as those provided by healthcare workers and first responders, including police and fire and rescue, and provision of utilities such as water, sanitation, and electricity are essential to minimize the effect of an epidemic. Maintaining vital services will result in the greatest good for the greatest number. Beyond maintaining vital services, there may be special groups to which priority should be given; for example, those most at risk of dying might be given preference, even though this may not fit with utilitarian theory. The general population should receive the vaccine on a first-come, first-served basis. Such a distribution theory would require maintenance of civil order.

3. Outline the steps to inform the HSOs and relevant government agencies about the plan and to involve them in the contingency planning for implementation. (Should law enforcement officials participate?)

- Obtain preliminary approval for the plan and process for contingency planning from the commissioner of health.
- Contact HSOs countywide and relevant government agencies to inform them of the planning effort and contingency planning. Give special attention to the HSOs' own disaster planning.
- Present a briefing of the contingency plan and its process and goals to stakeholders.
- Organize task groups composed of HSOs by specialization—hospitals, nursing facilities (NFs), and so forth—as well as first responders and other emergency providers.
- Receive task groups' reports.
- Integrate the findings/recommendations into the plan.
- Submit a draft for review by members.
- Perform a virtual drill of implementation of the plan.
- Undertake an actual implementation drill to implement the plan.
- Evaluate performance of the implementation drill.

4. Should the residents of Grant County be involved in the planning process? Justify your answer.

Yes. The general public has a vital role because there is much it can do to stem progression of an epidemic. Self-quarantine will diminish the spread of a communicable virus, and the public must be informed of the importance of staying in place and waiting out the peak of the epidemic. Self-quarantine means that the public will have to lay in a supply of food, water, batteries, and battery-powered radios and pay attention to special needs so that they will be self-sustaining as they stay in place. Knowledge that the county has a plan and is ready for the outbreak of a deadly virus will calm the public and diminish the likelihood of panic.

Additional Case Study 1: Reporting Suspected Child Abuse or Neglect

This case highlights management's role in obeying the law (and meeting ethical obligations) under circumstances in which clinical staff disagree and are unwilling to comply with the law. Instructors should place special emphasis on the political implications in the case, but they should make it clear that these do not override legal obligations.

Monkotsa state law requires health services professionals to report suspected child abuse or neglect to welfare authorities or the police. Roosevelt Hospital is a major teaching institution in the state's only metropolitan area. It has large emergency and outpatient departments. All attending physicians, house officers (residents), and clinical employees are told about the state law during orientation. This information is reiterated during hospital-sponsored continuing education programs. Roosevelt Hospital has written standard operating procedures that describe how to comply with the law. Forms to report suspected child abuse and neglect are provided.

You are the chief operating officer (COO) at Roosevelt. Last week, your assistant told you that far fewer suspected child abuse and neglect cases are being reported this year, which suggested to him that staff may not be reporting cases as aggressively. The matter must wait a few days, however, because you are going to the ACHE convocation, where you will be advanced to fellow.

You attend to the problem the following week. Because most emergency and outpatient care is provided by house officers, you ask to meet with the chief resident. She seems reluctant to discuss the matter, but with prompting, she confirms your assistant's assessment of the data. She tells you that pediatric residents are the most unwilling to report suspected abuse and neglect when doing so is not in the child's best interests. She tells you that most residents and the attending staff agree about selective reporting.

To your horror, the chief resident recounts two cases in which reports were made but the parents retained custody of the children. Both children suffered major trauma when the parents vented their frustration and anger about being reported. One child became paraplegic because of a spinal cord injury; the other had to have the fingers on one hand amputated because of burns sustained when his hand was held in a deep fryer.

The chief resident points out that the Hippocratic Oath requires physicians to do what they believe is in the patient's best interests. Somewhat sharply, she reminds you that the child is the patient, and the physician's moral duty lies in treating the child, not in intimidating the parents. In addition, effective medical care requires mutual trust. Trust will disappear if parents perceive the hospital and physician as agents of the government informing on them, and parents will not bring children in for treatment. She also notes that investigation may not substantiate the suspected abuse or neglect. The fact of being investigated by welfare authorities and police, however, stigmatizes the parents and violates the privacy of the family.

It is clear that the topic is both important and sensitive. You are obliged to identify for the chief resident the opposing arguments from your perspective and that of the hospital.

1. *What arguments can the COO make based on the law? Are these arguments based in morals or codes of ethics?*

- Not obeying the law puts the hospital's license at risk, subjects it to the potential for fines, and puts it at risk for civil damages. In addition, negative publicity is likely to result if it is reported that the hospital is not reporting cases of suspected child abuse. Physicians are moral agents in treating patients and must exercise independent judgment, but they also are part of society and must act morally by obeying the law, unless they choose to risk fines and imprisonment for civil disobedience.
- The law is the community standard for protecting children. Its application must avoid falsely accusing parents. Physicians need to report cases only if it is reasonably certain that abuse has occurred. The 2001 AMA "Principles of Medical Ethics" states that a "physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."⁷ This means that house staff

who are AMA members are acting unethically. They could/should seek to change the law, if they disagree with it.

- Physicians have an ethical (moral) duty to obey the law. Legally, if they fail to obey the law, their licenses are at risk. Tragedy may have resulted from some instances of reporting, but this is only one consideration. A rule utilitarian view (on the whole, more children will be aided than harmed by reporting) and a Kantian view (obeying the law) are duties that are borne by physicians.
 - At minimum, the hospital expects residents, who are its employees, to obey the law. Physicians serve the interests of the child/patient by reporting, because this offers the best hope of effective intervention. Absent intervention, abuse is likely to continue, with possibly disastrous results.
2. *Instead of addressing the issue with the chief resident, should the COO use formal managerial control over nursing and other employees to solve the problem? Why or why not?*

Reasons to Exert Control

- The COO must obey the law. When residents do not obey the law and are not forced to comply, another way to meet the requirements of the law must be found.
- Nurses and other staff in the emergency department (ED) and outpatient care are included in the statute and are clinically capable of determining whether there has been child abuse, especially if they receive special training.
- The hospital has an ethical obligation to protect the community, including a special duty to protect children.

Reasons Not to Exert Control

- Nurses and other staff will be perceived as interfering, and residents will resent being second-guessed.
 - The COO must be cautious because nurses and other staff may oppose reporting for the same reasons that physicians do.
 - Nurses and other staff may feel unqualified to make the judgment, think it is properly a physician's decision, and resent being asked to do a physician's job.
3. *Should the hospital try to modify state law by becoming involved in the political process? If so, what should it do, and who should do it?*

Hospitals are ethically and legally obligated to protect patients and work in the community's best interests. If the statute is defective and its implementation is difficult or ineffective, health services managers are ethically bound to speak out. They should exercise leadership to change the law. Steps include working with a friendly newspaper reporter to develop stories describing problems with, and ramifications of, the law; informally meeting with state legislators to discuss problems and changes; and contacting the state hospital association to enlist its support in changing the law. GB members and physicians should be urged to do the same.

4. *How much informal pressure should the COO put on the residents? What are the acceptable means of doing so?*

A physician is responsible for the medical education program in the hospital. The COO must work with and through that person or other channels that link medical education to senior-level management. Direct interaction with residents must be handled gingerly because physicians will understand decision making about abused children as primarily medical and will not react well to managerial involvement—it will be seen as interference, especially if it comes from a layperson (a nonphysician). The COO must ensure compliance with the law, however.

Additional Case Study 2: The Missing Needle Protector

This case focuses on the difficulties of reducing the clinical privileges of politically powerful members of the PSO. Middle-level managers (and senior-level managers) can be intimidated by them as well. A major issue is finding allies who are willing to support actions to curtail clinical privileges. This case should also sensitize students to the issues of impairment as they affect caregivers and managers.

E. L. Straight is director of clinical services at Hopewell Hospital. As in most hospitals, there are a few physicians who deliver acceptable but marginal-quality care. They tend to make more mistakes than the others and have more patients who go “sour.” After Straight took the position 2 years ago, new programs were developed, and clinical quality seemed to be improving.

Dr. Cutrite has practiced at Hopewell longer than anyone can remember. He was once a brilliant general surgeon, but he has slipped physically and mentally, and Straight is considering how to reduce his surgical privileges. The process is incomplete, however, and Cutrite continues to perform surgery.

The operating room supervisor came to Straight’s office one Monday afternoon. “We’ve got a problem,” she said, somewhat nonchalantly, but with a hint of disgust. “I’m almost sure we left a plastic needle protector from a disposable syringe in a patient’s belly—a Mrs. Jameson. You know what I mean, the protectors that are reddish-pink. They’re impossible to see in a wound.”

“Where did it come from?” asked Straight.

“I’m not sure,” answered the supervisor. “All I know is that the syringe was in a used surgical pack when we did the count.” She went on to describe the safeguards of counts and records. The discrepancy was noted when the records were reconciled at the end of the week. A surgical pack was shown as having a syringe that was not supposed to be there. When the scrub nurse working with Cutrite was questioned, she remembered that he had used the syringe, but when it was included in the count at the conclusion of surgery, she did not think about the protective sheath that must have been on it.

“Let’s get Mrs. Jameson back into surgery,” said Straight. “We’ll tell her we have to check her incision and deep sutures. She’ll never know that we’re really looking for the needle cover.” “Too late,” responded the supervisor. “She went home the day before yesterday.” Damn, thought Straight. “Have you talked to Cutrite?” The supervisor nodded affirmatively. “He won’t consider telling Mrs. Jameson that there might be a problem and readmitting her,” she said. “He warned us not to do anything either,” she added. “Cutrite claims it cannot possibly hurt her. Except for some discomfort, she’ll never know it’s there.”

Straight called the chief of surgery and asked hypothetically about the consequences of leaving a small plastic cap in a patient’s belly. The chief knew something was up but did not pursue it. He simply replied that it was likely there would be occasional discomfort but probably no life-threatening consequences. “Although,” he added, somewhat darkly, “one is never sure.”

Straight liked working at Hopewell Hospital and wanted to avoid a confrontation with Cutrite, who had declined professionally but was still powerful politically. Straight had resisted fingernail biting for years, but that old habit was suddenly overwhelming.

1. *What should Straight do? Why?*

Straight’s employment at Hopewell is in jeopardy, but Straight is ethically (and legally [in terms of tort liability]) bound to take action. As a manager, Straight is obliged to exercise control in such situations. Also important are ethical and legal obligations to protect patients and the fiduciary duty to safeguard corporate assets. Straight should take the following steps:

- Straight must act quickly to investigate, obtain the facts, and determine whether it is likely that the needle protector was left in Jameson’s belly.

- Straight should not inform Jameson unilaterally, at least not initially. Eventually (and sooner rather than later), ethics demand that Jameson be informed about what happened. If an HSO/HS does not reach this conclusion through internal negotiation, then informing the patient, or even going public with the matter, is consistent with the manager's ethical duty. Absent unequivocal support from management, such a step is likely to mean Straight's dismissal.
- If it is determined that the needle protector is likely to be inside Jameson, which Cutrite seems to acknowledge, Straight should meet with Cutrite. Straight might convince him that removing the needle protector, whether or not Jameson is told the truth at that point, to prevent further injury is his minimum legal (and ethical) duty.
- Straight has begun the process to reduce Cutrite's privileges, and the Jameson incident should be added to this information. Others must be convinced that Cutrite is a problem and action is necessary. Allies should be enlisted, including the PSO president and CEO.
- Straight should review PSO bylaws as to temporary suspension of privileges when patients are in imminent danger. This might be needed to prevent further admissions by Cutrite and to protect patients currently under his care at Hopewell. The processes that are specified in the bylaws and PSO rules and regulations must be followed.
- Straight is ethically obliged to prevent patient injuries that might result from treatment by marginally qualified practitioners. The least a manager must do is protect patients from harm—the principle of nonmaleficence.

2. What sources of guidance can Straight use?

Internal Sources of Guidance

- GB bylaws
- PSO bylaws, and rules and regulations
- Risk manager
- Director of quality improvement
- President of the PSO and CEO
- Hospital attorney
- Ethics committee or ethicist

External Sources of Guidance

- ACHE Code of Ethics
- Legal precedents involving similar cases in this state and elsewhere
- State statutes and regulations
- State board of medical licensure (in the case that Cutrite is impaired)
- The AMA's "Principles of Medical Ethics" and opinions of the AMA's Council on Ethical and Judicial Affairs

3. What steps should be taken to avoid similar problems in the future?

- Clarify and enhance the credentialing and recredentialing processes to permit thorough and expeditious action.
- Integrate quality improvement and risk management to identify more effectively the practitioners whose privileges should be reviewed and, perhaps, reduced.

- Build alliances with PSO members and administration to assist in handling such problems.
- Clarify the organizational philosophy (values) and derivative mission statement to address issues such as these that affect quality.
- Implement an education program to reinforce staff knowledge as to their role in protecting patients. They must know that protecting patients is among their most important ethical and legal responsibilities.
- Revise the method of counting instruments and supplies after surgery. A week is unacceptably long before a final reconciliation. More effective safeguards/systems are needed.

4. Is there anything disturbing about the attitudes of the operating room supervisor and chief of surgery? Explain.

The attitudes of the operating room (OR) supervisor and chief of surgery are troubling. The OR supervisor seems nonchalant, even cynical, about the incident with Jameson. This may be the result of unsuccessful efforts to remedy similar problems previously. Straight must try to convince the OR supervisor that things are changing and back up these words with actions. This may improve her attitude. Her dismissal is a last resort.

The chief of surgery's job is to know what is happening in surgery, and he should be vitally interested in identifying and solving problems. His lackadaisical attitude is antithetical, but it may result from inertia and previous lack of action. If Straight's initiatives do not stir greater responsiveness, Straight must work to replace him.

Straight is not free of blame, however. No action regarding Cutrite's privileges has been taken in the 2 years that Straight has directed clinical services. It is not clear how well Cutrite's problems have been documented—a crucial step to a disciplinary proceeding. Problems like this are easily put aside; they are difficult, unpleasant, and dangerous to one's continued tenure. Ethical (and legal) duties demand action, however.

Additional Case Study 3: The “Distracted” President of the Professional Staff Organization

“Distracted” understates the risks described in the case study. Often, hospitals compete with members of their PSOs. This case study highlights the even greater competitive and political problems that arise when a physician in a leadership position has dual loyalties that will lead to conflicts of interest.

You are the CEO of Valley Medical Center (VMC), a 350-bed tertiary care facility. VMC is a community hospital that serves a six-county region in the southwest United States. As with most community hospitals, VMC has a voluntary professional staff comprised of physicians and other licensed independent practitioners (LIPs) who have clinical privileges to provide care at VMC, but have no financial relationship with it. They bill patients and third-party payers directly for their services to hospitalized patients. VMC employs a vice president for medical affairs (VPMA), who is a member of the senior management team. In addition, there is a president of the professional staff who is elected by members of the professional staff organization (PSO). This individual represents and speaks for the PSO when interacting with VMC's management and its governance. Dr. Helen Major was recently elected president of the PSO by its members; she will take office in 30 days.

About a week after Dr. Major was elected, you learned that she had signed a contract to consult with a major competing hospital. You have not seen the contract, but the information suggests that the contract requires Dr. Major to *consult* on matters such as capital expenditures, establishment of new service lines, physician recruitment, and quality and medical staff disciplinary matters for your competitor hospital. These types of areas have been addressed in the past by senior leadership and the president of the PSO at VMC. This relationship with your competitor raises a significant duality of interests for Dr. Major.

You are in a quandary; economic, competitive, political, and mission problems are certain to arise. Time is short. Your stomach begins to churn and you find yourself reaching for the antacids.

1. Explain the authority relationships between the VPMA and the president of the PSO.

The VPMA is a member of the managerial hierarchy and reports to the CEO for matters related to the management of the medical staff and clinical programs. VPMAs are responsible for ensuring that the medical staff bylaws and rules and regulations are followed. In addition, they work with clinical managers (e.g., chiefs of clinical service or specialty) to help them effectively manage their clinical departments and activities in support of the hospital's mission. The president of the PSO is elected by the professional staff and is its representative to management and governance. This position has no line authority, but may be highly influential (depending on the incumbent) and has important liaison, integration, and communication roles.

2. What is the role of Dr. Major in terms of the relationship with members of the PSO?

Dr. Major functions in the roles noted above. It is customary that the president of the PSO attend high-level meetings that address hospital problems and during which long- and intermediate-range strategies are determined. Most meetings will include discussion of significant proprietary information. Such inside information is confidential and disclosing or acting on it outside the organization is a breach of fiduciary duty.

3. Identify the potential political issues that will arise, including their sources, if there are action(s) to prevent or mitigate the duality of interests Dr. Major has.

- a. Allegations that hospital management is attempting to control the PSO. *Source:* Members of the PSO.
- b. Disgruntlement by members of the PSO that their elected representative is being treated inappropriately. *Source:* Members of the PSO.
- c. Diminution of good feelings/relationships between PSO and management/governance. *Source:* Members of the PSO, but defensive and/or negative responses from management and/or governance will exacerbate the situation.

4. Outline a course of action that you would recommend to the board.

First, the board must be fully briefed about the situation. (The PSO bylaws and rules and regulations may provide guidance and, if so, should provide the context.) Background for the board should include comprehensive information about the level of access that the president of the PSO has (and must have to be successful) to confidential and proprietary information at VMC. Information about the legal implications of the issues raised by Dr. Major's consultancy should come from hospital counsel. The chair of the hospital ethics committee should participate as well.

The governing body, guided by its chair and the CEO, should develop a solution. Delay in solving this problem should be minimal because there is risk that Dr. Major will be involved in meetings and/or discussions that are confidential/proprietary.

Not to be forgotten is that a low-key, frank, and informal discussion with Dr. Major should be part of any solution. Bringing to her attention the conflicts that will arise as she performs her duties at a competing hospital may well cause her to recognize the problems and prompt her to resign her position as president of the PSO. Reason and calm should prevail. Precipitous action should be avoided.

Additional Case Study 4: The Scarlet Letter?

Dishonest CVs and resumes are a common problem across professional groups. This case study suggests the multi-dimensional aspects and sequelae of a situation in which a healthcare executive has purposefully misstated his credentials.

Franklin Franks is the CEO of Affiliated Nursing Facilities (ANF), an investor-owned system of long-term care facilities. He has held the position for almost 10 years. Recently, the board of directors of ANF received an anonymous letter alleging that Franks had misstated his

credentials as shown on his resume. The letter said that Franks did not have the graduate certificate in finance from a prestigious East Coast university that he supposedly earned 2 years prior to being appointed CEO of ANF. Although very skeptical of anonymous allegations, the board chair, Anne Wilson, reviewed the résumé that Franks had used when he was offered his position. Because of the sensitive nature of the matter, she personally sought to verify that Franks had earned the certificate. Her efforts were thwarted by the federal Family Educational Rights and Privacy Act of 1974, which requires that students consent prior to disclosure of education records.

Wilson met privately with Franks to address the allegation. Initially, Franks was vague and somewhat evasive. It was clear that he was embarrassed that his credentials were being reviewed, especially 10 years after being hired. Franks stressed two points: 1) the inclusion of the certificate was probably a clerical error that he would investigate; 2) his excellent performance for the past decade should cause any error to be forgiven—it was clear that he had the qualifications to perform as CEO. Franks stated that he would provide proof it was an innocent clerical error—thus implicitly acknowledging that the entry regarding the certificate in finance should not have been in his résumé.

Wilson told Franks that she wanted to see the explanation behind the “innocent” error. Wilson had been on the board of directors when Franks was hired. She remembered that Franks’s qualifications were reviewed extensively and that all of them had been important in the decision to hire him.

A week later Wilson was given a letter from Franks stating that he had been able to contact his former secretary and that she had confirmed his statement that a clerical error had caused the graduate certificate to be put in his résumé. Wilson asked for the secretary’s contact information. After delays and a need for further prompting, Franks provided it.

Wilson likes Franks. She was very disappointed when the former secretary told her that the only information she had put in the résumé had been expressly provided by Franks. It was now clear that Franks had lied in his résumé. Even more important, Franks had lied to Wilson when he was confronted and tried to blame his secretary for the error.

1. What are the issues in the case?

- a. Is there a qualitative distinction between the falsified résumé and the lies told when Wilson began her investigation? If so, how should each be treated?
- b. Franks’s honesty and performance, in general
- c. What other lies has Franks told?
- d. Should Franks be discharged?
- e. If discharged, what information should be included in a reference for Franks?

2. Outline a course of action for Wilson.

- a. Ask Franks for a full, written explanation of the facts and circumstances that led to the current situation.
- b. If possible, determine how widely it is known in the organization that there are questions about Franks’s résumé/credentials.
- c. Confer with the personnel committee of the board to develop a response/course of action.
- d. The result of conferring with the personnel committee should be that Franks must be fired. Questions to be answered: 1) Should Franks be allowed to resign? 2) Should he receive a severance payment (with or without such a clause in the contract [since Franks was hired using a misrepresented résumé, it can be argued that he is not entitled to severance, regardless of the contract’s terms])? 3) Should Franks be allowed to negotiate the substance of a letter of reference? If so, what should the verbiage be? 4) How should Franks’s departure be characterized/explained within the organization?

3. What should Franks do?

Franks should resign if he is allowed to do so. His credibility in the organization has been significantly compromised. Even if his credibility in the organization is not compromised now it will be when information about his misrepresented résumé is more widely known. It is easy to understand that he wanted to continue the deception that began with the falsified résumé. However, doing so only made matters worse and diminished the perception of his character in the eyes of the board and its chair.

Franks should try to negotiate a neutral letter of reference from Wilson. This means that the separation was voluntary and that Franks was an effective CEO. The condition that should be demanded by Wilson is that the résumé be purged of any reference to the certificate in finance.

Calls from prospective future employers regarding Franks's work at ANF are problematic. A question such as "Would you rehire Mr. Franks?" can be answered honestly, but without mentioning the falsified résumé. Arguably, this is morally justified if Franks resigned in the face of the issue. Had he been discharged, the response should be different.

4. How serious is the problem for the HSO? For Wilson? For Franks?

a. For the HSO

This issue is serious for the HSO. The information about the falsified résumé is almost certain to become known throughout the organization. This will diminish Franks's moral authority and cause similar collateral damage to that of the board. No one benefits from continuing the relationship with Franks.

b. For Wilson

Wilson's moral authority will be undermined because of Franks's diminished moral authority. Both will be tarred with the same brush because most observers will see them as one and the same. This is a serious problem for Wilson and requires direct, conclusive action.

c. For Franks

Franks will suffer a loss of moral authority when the information currently known to Wilson and the board becomes known within the organization. It is almost certain that this will happen; secrets only remain so for a time. The example set by Franks is not one that should be emulated within the organization and cannot be ignored. Example in leadership is key. There can be no effective leadership when managers use "Do as I say, not as I do" as a guideline.

Notes

1. *Black's Law Dictionary*, 8th ed. St. Paul, MN: West Publishing, 2004.
2. National Consensus Project for Quality Palliative Care. "Clinical Practice Guidelines for Quality Palliative Care," 2nd ed., 5. Pittsburgh: National Consensus Project for Quality Palliative Care, 2009.
3. Adapted from Darr, Kurt. *Ethics in Health Services Management*, 5th ed., 153–154. Baltimore: Health Professions Press, 2011; used by permission.
4. Adapted from Darr, Kurt. *Ethics in Health Services Management*, 5th ed., 138. Baltimore: Health Professions Press, 2011; used by permission.
5. Case study and answers to the questions were written by Gary E. Crum, Ph.D., M.P.H., District Director of Health (retired), Northern Kentucky Independent District Health Department. Used with permission.
6. Case study and answers to the questions were written by Gary E. Crum, Ph.D., M.P.H., District Director of Health (retired), Northern Kentucky Independent District Health Department. Used with permission.
7. American Medical Association. "Principles of Medical Ethics." <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>, retrieved January 6, 2014.

